

Vernick and Gopal, LLC
1244 Boylston St, Suite 303
Chestnut Hill, MA 02467
Tel 617-383-6800 Fax 617-383-6801

Date: _____

New Patient Registration Form

Acct# _____

Demographics:

Patient's Last Name: _____ First Name: _____

Social Security # (SSN): _____ Male [] Female []

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Mobile/Other: Phone: _____ Birthdate: ____/____/____

Marital Status: [] Married [] Divorced [] Single Email: _____

Emergency Contact: Name: _____ Relationship: _____

Best contact telephone#: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Membership ID# _____ Membership ID# _____

Carrier's Name and DOB: _____ Carrier's Name and DOB: _____

Relationship to patient: _____ Relationship to patient: _____

Referral Information:

Who referred you to our office today? How did you hear about our practice?

Primary Care Physician:

Name: _____ Address: _____

Telephone #: _____ Fax #: _____

Please list names of any ADDITIONAL PHYSICIANS that should receive notes from our office

1. Name: _____ Address: _____

Telephone _____ Specialty: _____

2. Name: _____ Address: _____

Telephone: _____ Specialty: _____

Acct# _____

Background Information

Please check as appropriate.

Federal Government Information Requirement

Preferred Language: English French Japanese Spanish Chinese Other _____

Patient Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or other Pacific Islander Caucasian/White Other/Unspecified

Patient Ethnicity: Hispanic or Latino Not Hispanic or Latino Other/Unspecified

Social History

Alcohol Use: Never Moderate Occasionally Social # Drinks per week: _____

Exercise Regularly: Yes No

Exposure to Fumes, Dust, Solvents or Airborne Particles: Yes No none known

Recreational Drug Use: Never Former Current

Smoking History: Current Every Day Current Some Days Former Smoker Never Smoker

Of Years of Active Smoking: _____ Years since quitting: _____

Other Tobacco Use? (Pipe, Cigars, Chew): _____

Pharmacy Information

Local Pharmacy Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Mail Order Pharmacy Name: _____ Mail Order ID: _____

Telephone # _____ Fax #: _____

Pharmacy Preference (please choose) Local Pharmacy: Mail Order:

Reason for TODAY's visit: _____

Acct # _____

Surgical History

Have you had a tonsillectomy? Yes No Year: _____

Cancer: Specify _____

Cardiac: Specify _____

Cosmetic: Specify _____

Ear Surgery: Specify _____

Nose Surgery: Specify _____

Throat Surgery: Specify _____

Other Surgery: _____

Family History

Illness/Condition	Father	Mother	Brother	Sister
Family History Unknown: Check box				
Abdominal Aortic Aneurysm				
Alzheimer's Disease				
Behavioral/Emotional Health				
Bleeding Disorders				
Brain/Nervous System				
Cancer				
Diabetes				
Hearing Loss				
Heart/Cardiovascular				
Genetic Disorders				
Migraines				
Respiratory Disorders				
Stroke				

Have you ever had a pneumonia immunization? Please circle one: Yes No Unknown

Acct # _____

Past Medical History

(Check the box to the left of the condition that you are currently being treated for or have been treated for in the past)

<input type="checkbox"/>	Allergies (Seasonal/Environment)	<input type="checkbox"/>	Deep Vein Thrombosis (DVT)	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Dermatologic (Skin)Disease	<input type="checkbox"/>	Lyme Disease
<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lymphoma
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>	Melanoma
<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	Eye Disease	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	Auto-Immune Disease	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	Myocardial Infarction
<input type="checkbox"/>	Behavioral Disorder	<input type="checkbox"/>	Gastrointestinal/GI Problems	<input type="checkbox"/>	Neurological Problems
<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	GERD/Reflux	<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	Renal Disease
<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>	Headaches (migraine, cluster)	<input type="checkbox"/>	Rhinitis
<input type="checkbox"/>	Cardiovascular (Heart Disease)	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Chronic Heart Failure (CHF)	<input type="checkbox"/>	High Blood Pressure (Hypertension)	<input type="checkbox"/>	Sinus Problems/Sinusitis
<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Transient Ischemic Attack (TIAs)
<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Coronary Heart Disease	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Crohns Disease	<input type="checkbox"/>	Kidney/Urinary Bladder Problems	<input type="checkbox"/>	Ulcers (other)
<input type="checkbox"/>	Cerebral Vascular Accident (CVA)	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Ulcers (stomach)

None of the above applies: check here

Review of Symptoms (ROS):

Identify which if any of the following you are currently experiencing:

<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Frequent Nose Bleeds	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Skin Lesions
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Difficulty Hearing	<input type="checkbox"/>	Joint/Muscle Pain	<input type="checkbox"/>	Vision changes
<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Weight gain/loss
<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Noises in Ear/Head	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	

Other Symptom(s) Not Listed: _____

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Medication History

Please list all medications that you're taking including over-the-counter medications, vitamins and other treatments. Please attach your medication list if more convenient.

Name of Medication Include over the counter medications	Dosage (mg/units/puffs/drops)

Patient reviewed and acknowledges that they are not taking any medications at this time: check here

Drug, Food and Latex Allergies

Drug Allergies: No Yes

If yes, please list Drug name and reaction:

Drug Name: _____ Reaction: _____

Drug Name: _____ Reaction: _____

Drug Name: _____ Reaction: _____

Latex Allergy: No Yes Reaction: _____

Shellfish Allergy: Yes No

Other Food Allergies: _____

Patient/Physician Acknowledgement Signatures

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

David M. Vernick, MD, FACS

Harsha V. Gopal, MD, FACS

E. Ashlie Darr, MD

Name: _____

Date: _____

ACCT# _____

SINO-NASAL OUTCOME TEST (SNOT-22)

1. Directions: Circle corresponding number (1,2,3,4,5). Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: ☐☐	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Nasal obstruction	0	1	2	3	4	5
5. Loss of smell or taste	0	1	2	3	4	5
6. Cough	0	1	2	3	4	5
7. Post - nasal discharge	0	1	2	3	4	5
8. Thick nasal discharge	0	1	2	3	4	5
9. Ear fullness	0	1	2	3	4	5
10. Dizziness	0	1	2	3	4	5
11. Ear pain	0	1	2	3	4	5
12. Facial pain/pressure	0	1	2	3	4	5
13. Difficulty falling asleep.	0	1	2	3	4	5
13. Wake up at night	0	1	2	3	4	5
15. Lack of a good night's sleep	0	1	2	3	4	5
16. Wake up tired	0	1	2	3	4	5
17. Fatigue	0	1	2	3	4	5
18. Reduced productivity	0	1	2	3	4	5
19. Reduced concentration	0	1	2	3	4	5
20. Frustrated/restless/irritable	0	1	2	3	4	5
21. Sad	0	1	2	3	4	5
22. Embarrassed	0	1	2	3	4	5

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Name: _____ Today's date: _____

Date of Birth: _____

Epworth Sleepiness Scale

Answer how likely are you to doze off or fall asleep in the following situations.

Answer how you felt over the past week or so.

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Number	Question
_____	1. Sitting and reading
_____	2. Watching TV
_____	3. Sitting inactive in a public place (e.g. theater or meeting)
_____	4. As a passenger in a car for an hour ride without a break
_____	5. Lying down to rest in the afternoon, when able
_____	6. Sitting and talking to someone
_____	7. Sitting quietly after a lunch, without alcohol
_____	8. In a car, while stopped for a few minutes in traffic